Consensus Core Set: Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and Primary Care

The Core Quality Measures Collaborative (CQMC) core measure sets (core sets) are intended for use in value-based payment (VBP) programs and may also be used to drive improvement in high-priority areas. The core sets can be used in their entirety to holistically assess quality or can serve as a starting point when selecting measures to meet specific goals. The CQMC core sets are developed and maintained using a multistakeholder, consensus-based process and established measure selection principles. Measure specifications and details are linked in the *CBE Number* column, and additional considerations for use are included in the *Notes* section of the table below.

ACO and PCMH / Primary Care Measures

The CQMC core set measures focus on ambulatory care measures at the clinician reporting level. The ACO/PCMH/Primary Care core set includes ten measures that have been tested for reliability and validity at the clinician (individual or group/practice) reporting level. The remaining core set measures address important topics related to ACOs, PCMHs, and primary care, but they have not been tested at the clinician level of analysis. When using measures specified outside the clinician level of analysis, core set users should ensure adequate measure denominator size based on their patient population.

Measure Topic	CBE Number	Measure	Steward	Level of Analysis	Notes
Behavioral Health	1885	Depression Response at Twelve Months- Progress Towards Remission	Minnesota Community Measurement (MNCM)	Clinician, Facility	Telehealth eligible
	0418 / 0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services (CMS)	Clinician	No longer CBE endorsed. Developer plans to maintain measure independently. eCQM available* Telehealth eligible for CMS programs in 2023
	2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling†	National Committee for Quality Assurance (NCQA)	Clinician	-

Measure Topic	CBE Number	Measure	Steward	Level of Analysis	Notes
Behavioral Health	3541	Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)	Pharmacy Quality Alliance (PQA)	Health Plan	This measure is specified at the plan level and can be used to inform quality improvement efforts.
Cardiovascular Care	0018	Controlling High Blood Pressure	NCQA	Health Plan	eCQM available* Telehealth eligible Use updated HEDIS specifications.
	N/A	Statin Therapy for Patients with Diabetes (SPD)	NCQA	Health Plan	HEDIS specifications
	N/A	Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD)	NCQA	Health Plan	HEDIS specifications
Care Coordination/ Patient Safety	N/A	Transitions of Care (TRC)	NCQA	Health Plan	-
	3617	Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure	American Board of Family Medicine (ABFM)	Clinician	-
Diabetes	0059	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA	Health Plan	eCQM available* Telehealth eligible
	0055	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	Clinician, Health Plan	eCQM available* Telehealth eligible
	N/A	Kidney Health Evaluation for Patients with Diabetes	NCQA	Health Plan	-
Patient Experience	0005	CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 – Adult, Child	Agency for Healthcare Research and Quality (AHRQ)	Clinician	Ensure adequate denominator volume AHRQ guidance
	3568	Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)	ABFM	Clinician	-

Measure Topic	CBE Number	Measure	Steward	Level of Analysis	Notes
Prevention & Wellness	0032	Cervical Cancer Screening	NCQA	Health Plan	eCQM available* Telehealth eligible for CMS programs in 2023
	N/A	Non-recommended Cervical Cancer Screening in Adolescent Females (NCS)	NCQA	Health Plan	HEDIS specifications
	2372	Breast Cancer Screening	NCQA	Health Plan, Integrated Delivery System	eCQM available* Telehealth eligible
	0034	Colorectal Cancer Screening (COL)	NCQA	Health Plan, Integrated Delivery System	eCQM available* Telehealth eligible
	0028 / 0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention†	NCQA	Clinician	eCQM available* Telehealth eligible for CMS programs in 2023
	0421 / 0421e	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS	Clinician	No longer CBE endorsed. Developer plans to maintain measure independently. May be inappropriate for elderly patients, which is reflected in the list of measure exclusions. eCQM available*
	N/A / 3059e	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (MIPS ID 400)	American Gastroenterological Association (AGA)	Clinician	eCQM available*
Pulmonary	0058	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	NCQA	Health Plan	Telehealth eligible
	1800	Asthma Medication Ratio	NCQA	Health Plan	Telehealth eligible

Measure Topic	CBE Number	Measure	Steward	Level of Analysis	Notes
Readmissions	1768	Plan All-Cause Readmissions (PCR)	NCQA	Health Plan, Integrated Delivery System	No longer CBE endorsed. HEDIS specifications should be used. Recommended for use at ACO level. Ensure adequate denominator volume.
Utilization & Overuse	0052	Use of Imaging Studies for Low Back Pain	NCQA	Health Plan, Integrated Delivery System	No longer CBE endorsed.

*Separate benchmarks should be used based on the reporting method.

† This measure is a cross-cutting measure that may be highly relevant across multiple core sets.

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Gap Areas for Future Consideration or Measure Development

Priority Gaps

- Patient-reported measures
- Stratification of existing measures to identify health disparities
- Unnecessary services and waste/overuse
- Misdiagnosis/delayed diagnoses
- Integration across settings/specialties and populations

Additional Gap Areas

- Appropriate pain management
- Behavioral health and substance use
- Advanced illness, hospice care, and palliative care
- Health related quality of life
- Composite measures
- Goals of care and patient education
- Contraceptive care measures tested at the clinician level
- Medication adherence
- Shared decision-making
- Supplementing core set with population-based outcome measures to address social determinants of health (SDOH) and development of measures to address disparities

Measures to Consider in Future Core Set Versions

- #3455 *Timely Follow-Up After Acute Exacerbations of Chronic Conditions*
- #1598 *Total Resource Use Population-based PMPM Index*
- *Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions* (or similar measure addressing this topic)
- #0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- MUC21-125 *Psoriasis – Improvement in Patient-Reported Itch Severity*
- MUC21-135 *Dermatitis – Improvement in Patient-Reported Itch Severity*
- MUC21-136 *Screening for Social Drivers of Health*
- MUC21-134 *Screen Positive Rate for Social Drivers of Health*
- *#3665: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood*
- *#3666: Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain*

Core Set Updates for 2022

Updated notes related to telehealth eligibility for all measures
Measures 0032, 0028/0028e, and 0418/0418e remain telehealth eligible for CMS programs in 2023; the notes on these measures have been updated to reflect this continued eligibility.

Updated note related to measure 0421/0421e: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
The Workgroup noted reports of healthcare systems enforcing this metric for older adults, who were referred for unnecessary weight loss follow-up plans. A note has been added to the core set to emphasize that this measure's exclusions include "elderly patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions."

Added measure 3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)
This measure addresses a priority gap area (patient-reported outcomes) and provides insight into meaningful aspects of the long-term primary care provider relationship (e.g., integration of care, prioritization, personalized care) as opposed to experiences during a single healthcare encounter.

Added measure 3617: Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure
This recently endorsed measure addresses continuity of care, a priority gap area for the ACO/PCMH/PC core set.

Added measure 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy
This measure addresses patient safety and can help clinicians identify patients at risk of unnecessary long-term opioid use. This measure is specified at the health plan level of analysis, but the Workgroup recommended that this measure be used to inform quality improvement efforts.

Replaced measure 0097: Medication Reconciliation Post-Discharge with N/A: Transitions of Care
The workgroup elected to replace #0097, which is no longer used alone by the steward and was integrated into NCQA's *Transitions of Care* measure in 2018. The *Transition of Care* measure includes four components – notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge – key to smooth transitions of care.